IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 9085

August 18, 2006

Kelly Spiers, Administrator
Twin Falls Care Center
674 Eastland Drive
Twin Falls, ID 83301

Provider #: 135104

Dear Mr. Spiers:

On **August 11, 2006**, a fire safety survey was conducted at Twin Falls Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be widespread deficiencies that constitute no actual harm, but have potential for more than minimal harm and are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 31, 2006**. Failure to submit an acceptable PoC by **August 31, 2006**, may result in the imposition of civil monetary penalties by **September 20, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **September 15, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 15, 2006**. A change in the seriousness of the deficiencies on **September 15, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 15, 2006** includes the following:

Denial of payment for new admissions effective **November 11, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 11, 2007**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact me with your written credible allegation of compliance at the following address:

Bureau of Facility Standards — DHW

3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 11, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR 488.331, you have the opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send a written request which states the specific deficiencies being disputed, and explains why you are disputing those deficiencies. This request must be received by **August 31, 2006**.

All required information should be as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

If your request for informal dispute resolution is received after **August 31, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction

MPG/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story structure of Type V(111) construction that was built in 1987. The building is protected throughout by an automatic fire extinguishing system. Additionally, the facility has a complete fire alarm system that includes smoke detection in all corridors and open spaces. The facility is currently licensed for 116 SNF/NF beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on 11 August, 2006. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, adopted 11 March, 2003. In accordance with CFR 42, 483.70. The Survey was conducted by: Chris Laumann, Health Facility Surveyor.	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Twin Falls Care Center does not admit that the deficiencies listed on State Form 6899 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings all deficiencies, statements, facts, and conclusions that form the basis for each deficiency." RECEIVED AUG 30 2006 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	8-29-6

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation it was determined that the facility failed to maintain smoke barriers between smoke compartments in a state to resist smoke for at least one half hour. Due to the extent of the penetrations in every fire wall within 5 of 5 corridors, the integrity of the smoke compartmentation was compromised, this finding jeopardized the safety of all 84 residents and every staff member within the facility. Findings include: 1. During a facility tour on 11 August, 2006 between the hours of 12:30 PM and 4:30 PM, it was observed that all smoke barriers located; within the 100 corridor, the 200 corridor, the 300 corridor, 400 corridor, and, the dining area corridor as well as the administrative core. Each barrier had between 3 to 6 holes ranging in size from a half inch in diameter to 4 inches in diameter penetrating the barrier walls above the false ceilings, directly above each fire door. This	K 025	**K025 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** The holes in the smoke barriers walls were fixed immediately with the proper materials. **K025 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected.	

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K 025	Continued From page 2 compromised the integrity of the required 1 half hour resistive rating of the smoke barriers. In accordance with NFPA 101 Life Safety Code section 8.3, smoke partitions are required to be constructed to provide at least a one half hour fire resistance rating. Observations were witnessed and noted by surveyor and facility maintenance supervisor.	K 025	**K0255 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Maintenance will monitor all construction done on the facility to ensure that if any damage occurs to the firewalls it will be fixed immediately. Audits will be done quarterly to ensure that no other damage has occurred. **K025 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Safety committee will review audits quarterly to ensure compliance. After compliant audits will be done as needed focusing on after any construction, or maintenance is done. **Persons Responsible:** Boyd Stokes, Maintenance director. Compliance Date: 8-14-06	

Bureau of Facility Standards

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The facility is a single story structure of Type V(111) construction that was built in 1987. The building is protected throughout by an automatic fire extinguishing system. Additionally, the facility has a complete fire alarm system that includes smoke detection in all corridors and open spaces. The facility is currently licensed for 116 SNF/NF beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on 11 August, 2006. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The Survey was conducted by: Chris Laumann, Health Facility Surveyor	C 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Twin Falls Care Center does not admit that the deficiencies listed on State Form 6899 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings all deficiencies, statements, facts, and conclusions that form the basis for each deficiency." RECEIVED AUG 30 2006 FACILITY STANDARDS	
C 230	02.106,02,b b. Existing facilities licensed prior to the effective date of these rules, regulations and minimum standards and in compliance with a previous edition of the Life Safety Code may continue to comply with the edition in force at that time. This Rule is not met as evidenced by: ;	C 230	**See plan of correction for K025.**	

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator 8-29-6

Bureau of Facility Standards

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C 230	Continued From page 1 Refer to Federal tag K 0025 as it relates to maintaining smoke barriers, which can be found on federal form CMS 2567.	C 230		